NUBC Meeting Summary
May 7 & 8, 2003
Chicago, Illinois

NUBC/NUCC Combined Meeting

- HIPAA Transition Issues

  Discussion:

  There was general agreement at the Joint NUBC/NUCC meeting that it was necessary to provide guidance to the industry to assist in the transition from the current flat file formats, UB for institutional services and NSF for professional services. The discussion centered on issues associated with submissions before and after October 16, 2003 as well as situations that would require re-submissions that span that date. Until the enforcement rule has been published, there are unanswerable questions about the actions that will take place for non-compliance. The purpose of this discussion was to raise the pertinent questions as well as some brainstorming about the best place to get those questions answered. As a committee, the questions below will be presented to the Department of Health and Human Services for their opinion.

  - Is the date of service or the date of discharge the determining factor for when the old formats end and the new formats begin?
  - What should happen with monthly split bills?
  - What should happen with recurring services?
  - What should happen with interim bills?
  - What should happen with bills that have the service dates that span the October 16, 2003 date?
  - How long will vendors support old formats?
  - How will re-billing for services that adjudicated prior to October 16, 2003 in the old formats occur? (note: this re-billing could be for secondary bills, error correction, or pending of claims for medical record review

- Consumer-Purchaser Disclosure Project

  Discussion:

  A representative, Dr. Arnie Millstein, of the Consumer-Purchaser Disclosure Project presented a business case to the joint NUBC/NUCC meeting for the collection of additional data to support generation of quality measures for health care services. The premise of this proposal is that the quality of health care in the United States can be improved by measuring the quality of care through data and linking that to the

reimbursement providers receive for that care. Dr. Millstein suggested that a 3-tiered payment system be established based on the history of quality care provided. The quality indicators used in determining the reimbursement tier would be generated from historical provider data. Below are the highlights of Dr. Millstein's presentation. His PowerPoint slides are available upon request.

- The Institute of Medicine reports on "Crossing the Quality Chasm" and "To Err is Human" are alarming in their assessment of the quality of care being provided in this country.
- Our current system has an offensive amount of waste and hazard
- There are significant consumer service issues
- Our health care system is described by some as a 50 / 50 medicine, where half the time we get care that helps and half the time we get care that does not help.
- Purchasers of health care do bear some responsibility about our current system, since in the past these purchasers bought on price and not quality
- Changes are needed to emphasize quality of care along with providing financial incentives to effect that change.
- The cost of athe additional data collection requested was estimated at about $15 per discharge.
- The necessary new data elements were a flag for each secondary diagnosis code indication if present on admission, a unique physician identifier for each hospital procedure, vital signs at admission, key lab values at admission, Do Not Resuscitate order within the first 24 hours, and time of admission, discharge, as well as procedure.
- CPT4 / HCPCS Codes need to be enriched to incorporate quality measures in codes. In the current environment payers have not in the past recognized this type of coding for adjudicating health claims.

Dr. Millstein's concerns were recognized by the committee, but there were many concerns raised on how such a system could be implemented in a fair and equitable manner. Below is a summary of those concerns.

- Everyone agreed that the increased amount of data needed to support such a payment system would add to the cost of health care. There was concern about that cost and there were some suggestions that the cost estimate provided by Dr. Millstein was too low.
- There were questions about how the quality indicators would fairly assess the quality of care by providers.

- There were suggestions that before a change like this is implemented nationally, it would be wise to fund a pilot to test the viability of such a system
- There were questions about the 6 new data elements that were requested. Were each of the variables needed for all discharges? Will these added variables be all that is necessary to accurately determine the quality of care? Is the UB-92 the correct vehicle for collecting all this information? What provider information infrastructure changes will be necessary to support this additional data?
- How do the data elements requested compare to those requested by other bodies for performance assessment purposes?
- Concern about using the paper form to collect this data. There was strong support for the opinion that this data should be transmitted electronically to reduce the cost and the burden for providers and payers.

Action:

After hearing the discussion, the committee agreed that a letter of appreciation should be sent to Dr. Millstein. As part of this letter, the committee would indicate that this initiative to measure the quality of care is important and that it wanted to stay involved in the process.

Public Health Note: From a public health perspective, this dialog is significant. Public Health systems in this country have long advocated the collection of data to better assess the risk and quality of care. The alliance of business that brought this proposal forward to the NUBC and NUCC is likely to be an important ally for years to come. At the same time, the alliance needs assistance in understanding the current encounter standards and the processes for modifying those standards. Your public health representatives to both committees have volunteered to participate in this initiative above and beyond any official involvement by the NUBC and NUCC. They have begun discussions with the Disclosure project about possible uses of the Health Care Service: Data Reporting Guide, developed by the Public Health Data Standards Consortium, in piloting the project; several of the elements requested are already included in the Guide or potentially could be collected using the NUBC condition, occurrence or value codes available for assignment by the Consortium. We are excited about this initiative and the possibility that this partnership will widen the support for developing reliable quality measures that will improve the quality of health care in this country. This discussion is a prime example of why public health folks need to be involved in the national standards development process.

NUBC Opem Meeting

- Minutes approved with minor modifications for the following:
  - February 24 & 25, 2002 meeting
  - March 14, 2003 conference call
  - March 26, 2003 conference call
  - April 9, 2003 conference call
  - April 23, 2003 conference call

  It should be noted that the minutes for NUBC meetings and conference calls are available on the NUBC web site: www.nubc.org

Deferred Coding Requests

- The American Managed Behavioral Healthcare Association (AMBHA) returned with a revised proposal for new revenue categories for Community Behavioral Health Program, Group Home, Halfway House, Intensive Outpatient Program, Residential Treatment Acute, and Supervised Living.

  Discussion

  The following issues were raised discussing the revised proposal. Listed below are the highlights of those questions.

  - How will Medicare pay with any proposed new codes?
  - Does the location of the service also imply the type of service being delivered?

  It was unclear if Medicare will pay with the proposed new codes. The answer is that the location of the service does imply the type of service being delivered. The implication of that is that changes to the Type of Bill codes would not satisfy the business need of the AMBHA.

  Action:

  This request was approved. A new revenue category 100X was approved with the following sub-categories – General (0), Residential Psychology (1), Residential Chemical Dependency (2), Supervised Living (3), Halfway House (4), Group Home (5). It was also approved to make wording changes to the 090X and 091X revenue codes. The effective date for both these changes is October 16, 2003.

- The request for codes related to Medicaid spend down was considered again.

  Discussion

  There was some dialog about the proper wording of the request for two new codes, a Value Code and an Occurrence Code.

Action

An Occurrence Code (A4) as the date patient becomes eligible due to medically needy spend down was approved. A Value Code (66) for Medicaid client spend down liability was also approved. The effective date for both of these codes is October 16, 2003..

- The New Jersey state billing committee re-submitted a revised proposal to nationalize some of the local codes they had defined as part of their HIPAA compliance plan.

Discussion

As a follow up to discussions that occurred during a conference call, the New Jersey requestors re-submitted a revised proposal. There were requests to:

- Report Acute Care Days, SNF Days, ICF Days, and Residential Days
- identify some clinic types
- identify newborn birth order
- codes associated with reimbursement for charity care

Action

The committee approved Occurrence Span Codes for ICF (M3) and Residential Days (M4). Through the use of these Span Codes and an existing code for SNF (75), New Jersey will be able to calculate the number of days from the respective data ranges. The committee recommended that the Acute Days be calculated from the admission and discharge dates.

The request for clinic codes. The committee continues to think that this business need can be satisfied using a combination of taxonomy and diagnosis codes.

The request to identify newborn birth order was denied. The committee believes the current coding would be sufficient to satisfy this business need.

The request to define codes needed for reimbursement for charity care was deferred until a conference call so New Jersey representatives can be present to provide further clarification on their business need.

Public Health Note: It is important to note that before new codes are requested alternatives using existing codes be considered. The NUBC

has been very consistent sending this message. As public health data systems begin requesting national codes, the first step should always be to look to existing codes. By doing so, the credibility of public health requests will be enhanced.

New Coding Requests:

- There was a request to change the Title and Sub-category names of the 079X (Lithotripsy) to be more inclusive of other types of shock wave therapy.

  Discussion:

  The committee agreed in principal with this request, pending further research on the accuracy of the wording as well as more detailed analysis about any residual impact of such a change.

  Action:

  This request was deferred until further analysis completed.

- Illinois Request

  Discussion:

  The Illinois Department of Public Aide (IDPA) requested a new Value Code to denote the "Number of Outpatient Departments Visited." They currently get this information from a non-standard use of the 0001 total charges revenue code. The committee agreed that this data request would place too large a burden on the provider community.

  Action:

  This request was not approved.

  Public Health Note: It is important to note that HIPAA is definitely changing the way the NUBC and other standard development organizations are dealing with single use non-standard data requests. All of these types of requests are routinely being denied or deferred until greater national consensus can be achieved. This is an important lesson for us in public health as we enter the standards game as an up and coming player.

- Colorado Request

  Discussion:

Colorado Medicaid requested new Occurrence Span codes to indicate post eligibility treatment of income (PETI) payments. The purpose of this request was not clearly defined on the documentation provided to the NUBC members.

Action:

This request was deferred until more clarification is provided.

Public Health Note: The standards content and development organizations all require a clear business case be established prior to establishing a national standard. This is another important lesson for us in public health. Data requests that do not have a broad use case are not likely to become a national standard. It is important that we in public health work to establish well defined business cases that are national in nature.

- Pennsylvania Request

Discussion:

Pennsylvania Medicaid requested three Value Codes for drug deductions, Insurance Premiums, and other medical expenses. The business case for this request did not establish a national need for this request.

Action:

This request was deferred to the National Medicaid EDI HIPAA (NMEH) to establish a national business case for this request. After NMEH establishes that business case, the NUBC will again consider this request.

Public Health Note: See Public Health Note above.

DSMO Requests:

- Request Number 759 was approved. This request provides support for ICD-10 in the X12 standards.
- Request Number 761 was no longer necessary, since the changes in the 4050 version of the Institutional Claim implementation guide address this need. This request suggested changes in the situational wording for the SV2 segment.
- Request Number 763 was abstained from by the NUBC. This request suggested a change in the SV1 for professional services.
- Request Number 767 was approved. This request suggests three new codes (Inpatient services only, Outpatient services only, & Emergency services only) be added to the EB03 data element.

- Request Number 771 was disapproved. This request suggests a need to provide better clarification with the current race & ethnicity codes in the 4010 version of the X12 standard. The committee felt that CMS should be the one providing guidance as a solution for this request.
- Request Number 773 was approved. This request addresses the issue of "snowbirds" and clarifying where claims would be sent for patients with multiple addresses.
- Request Number 781 was disapproved. This request had multiple requests for Ambulance claims. The committee felt more justification was necessary for each of the components of the request.
- Request Number 784 was deferred. This request suggested changes to the HSD segment on professional claims to define the interval of a visit.
- Request Number 788 was rejected. This request was to use the PAT segment to report newborn birth weight. The NUBC has defined a value code (54) for this purpose.
- Request Number 795 was rejected. This request asked that loops be re-initiated for the reporting of the Referring Provider. The DSMO process already addressed this issue.
- Request Number 800 was deferred. This request suggests changes in the Release of Information code list in the CLM09 data element. Before action is taken on this request the NUBC felt is was necessary to find out if OCR has already published a guidance on this issue.

Other Issues:

- Review of 4050 Institutional Implementation Guide

  Discussion:

  A work group chaired by Todd Omundson reviewed the 4050 draft of the 837 Institutional implementation guide. This review compared the DSMO requests with the associated changes in the guide. Discrepancies were noted and submitted as comments to the online comment process on the Washington Publishing Company web site.

- UB-02

  Discussion:

  Within the next few weeks a new version of the UB-02 form will be distributed to committee members for further review. That version of the UB-02 form will be discussed on a June 18th conference call. It is expected that a vote on the final version of the UB-02 form will occur during the August NUBC meeting.

- Inpatient / Outpatient White Paper

Discussion:

At the May NUBC meeting a work group was formed to develop a white paper to better clarify a definition of Inpatient and Outpatient services. At this meeting the first draft of the "statement of the problem" was discussed. Based on this discussion revisions will be made and additional components of the white paper will be developed for future discussion. There was continued consensus that this is an important issue that will provide valuable guidance in an area of great ambiguity in the industry.

Public Health Note: This is also an important issue for Public Health data collection systems. The lack of clear definition of inpatient and outpatient services is a source of poor data quality in discharge data systems today. Participation in this discussion is critical to improvement in the quality of public health data in the future. This is just another example of the importance in public health active participation in the standards process.

Next Meeting Dates

- Note there will be frequent Conference Calls over the next year to address the various state coding issues that stand in the way of HIPAA compliance.
- August 5 & 6, 2003 in Baltimore, Maryland
- November 13 & 14, 2003 in Chicago, Illinois